IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005258

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Kate Despot
Deceased:	Antonio 'Tony' Vitelli
Date of birth:	14 May 1955
Date of death:	15 September 2023
Cause of death:	1(a) Papillary urothelial cancer with metastases to liver, lymph node and peritoneum
Place of death:	Grace McKellar Centre Ballarat Road North Geelong, Victoria 3215
Keywords:	In care, disability, natural causes

INTRODUCTION

1. On 15 September 2023, Antonio 'Tony' Vitelli (**Mr Vitelli**) was 68 years old when he died at the Grace McKellar Centre.

2. At the time of his death, Mr Vitelli resided at 600 Anakie Road in Lovely Banks, and was receiving care from disability support services provider, Scope Australia (**Scope**). Mr Vitelli had previously lived at Colanda Institution before it closed in 2019 and had a longstanding relationship with his support worker of 12 years.[1]

3. Mr Vitelli's medial history included a moderate intellectual disability, chronic paranoid schizophrenia, and autism spectrum disorder. On 6 March 2022, he was further diagnosed with inoperable bladder cancer.[2]

THE CORONIAL INVESTIGATION

4. Mr Vitelli's death was reported to the Coroner because it fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**).[3] Mr Vitelli's was a *"person placed in… care"* pursuant to the definition in section 4 of the Act, as Mr Vitelli was *"a prescribed person or a person belonging to a prescribed class of person"* due to his status as an *"SDA resident residing in an SDA enrolled dwelling."*[4]

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Vitelli's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Mr Vitelli including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] Statements of Salvatore 'Sam' Vitelli and Ralph Vitelli.
[2] Statement of Belinda Beck.
[3] Section 4(1), (2)(c) of the Act
[4] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *"prescribed person or a prescribed class of person"* includes a person in Victoria who is an *"SDA resident residing in an SDA enrolled dwelling",* as defined in Reg 5.

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. On 29 August 2023, Mr Vitelli presented to University Hospital Geelong with fever, rigors and tachycardia. Preliminary investigations yielded a diagnosis of escherichia coli (**e. coli**) bacteraemia secondary to a urinary tract infection for which his General Practitioner (**GP**) had commenced him on a course of antibiotics.[6]

9. Further scans showed that Mr Vitelli's urothelial cancer had significantly progressed.[7]

10. Medical staff met with Mr Vitelli's family and determined that interventions would cause significant distress and antibiotics were unlikely to prevent further infections.

11. Mr Vitelli was transitioned to comfort care and he sadly died on 15 September 2023.[8]

Identity of the deceased

12. On 21 September 2023, Antonio Vitelli, born 14 May 1955, was visually identified by his brother, Mr Salvatore 'Sam' Vitelli.[9]

13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 22 September 2023 and provided a written report of her findings dated 25 September 2023.[10]

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[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] Statements of Dr Reditta Tumali and Dr Peter Eastman.

[7] Ibid.

[8] Ibid.

[9] Statement of Identification dated 21 September 2023.

[10] Medical Examiner's Report of Dr Yeliena Baber dated 25 September 2023.

15. Dr Baber provided an opinion that the medical cause of death was 1(a) papillary urothelial cancer with metastases to the liver, lymph node and peritoneum.

16. Dr Baber determined that the death was due to natural causes.

17. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

18. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Antonio 'Tony' Vitelli, born 14 May 1955;

    b) the death occurred on 15 September 2023 at Grace McKellar Centre Ballarat Road, North Geelong, Victoria 3125 from papillary urothelial cancer with metastases to liver, lymph node and peritoneum; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Vitelli's family, loved ones and carers for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Mr Salvatore 'Sam' Vitelli, Senior Next of Kin

Barwon Health

Senior Constable Thomas Kerr, Coroner's Investigator

Signature:

Coroner Despot

Date: 30 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.